Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DIPTI PATEL DC
PAIN AND RECOVERY CLINIC NORTH
6660 AIRLINE DRIVE
HOUSTON TX 77076

Carrier's Austin Representative Box
#15

MFDR Date Received
JANUARY 14, 2009

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-09-5183-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility obtained pre-authorization for these services."

Amount in Dispute: $563.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "An attempt to resolve was made as checks issued. Provider declined resolution."

Response Submitted by: Gallagher Bassett Services, 5116 Bissonnet, Suite 364, Bellaire, TX 77401

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 3, 2008	CPT Code 97545-WH x 1 unit	$102.40	$8.54
September 3, 2008	CPT Code 97546-WH x 5 hours	$256.00	$256.00
September 5, 2008	CPT Code 97546-WH x 4 hours	$204.80	$5.70
TOTAL		$563.20	$270.24

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes.
2. 28 Tex. Admin. Code §134.600 sets out the fee guidelines for the reimbursement of workers' compensation non-emergency health care requiring preauthorization provided on or after May 2, 2006.

3. 28 Texas Administrative Code §134.204 sets out fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 30, 2008
   - A – SERVICE IS DENIED FOR LACK OF PROOF OF PRE-AUTHORIZATION.

   Explanation of benefits dated January 22, 2009
   - M – PAYMENT HAS BEEN RECOMMENDED AT FAIR AND REASONABLE RATE.

Issues

1. Does a preauthorization issue exist in this dispute?
2. Is the requestor entitled to additional reimbursement for CPT codes 97545-WH and 97546-WH?

Findings

1. 28 Texas Administrative Code, Section §134.600(p) states "Non-emergency health care requiring preauthorization includes: (4) all non-exempted work hardening or non-exempted work conditioning programs."

   28 Texas Administrative Code, Section §134.600(a)(4) states "Division exempted program: a Commission on Accreditation of Rehabilitation Facilities (CARF) accredited work conditioning or work hardening program that has requested and been granted an exemption by the division from preauthorization and concurrent review requirements."

   The requestor did not submit documentation to support that the disputed work hardening program was granted an exemption by the division; therefore, preauthorization was required.

   28 Texas Administrative Code, Section §134.600(p)(4) requires preauthorization of "all non-exempted work hardening or non-exempted work conditioning programs." On August 25, 2008, the respondent gave preauthorization for the Work Hardening Program, 5 times a week for 2 weeks under authorization number 2643766 to be performed between August 19, 2008 and October 19, 2008.

   The Division concludes that preauthorization was obtained for the three disputed work hardening sessions rendered from September 3, 2008 through September 5, 2008. Therefore, a preauthorization issue does not exist in this dispute.

2. 28 Texas Administrative Code, Section §134.204(h)(1)(B) states, "If the program not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

   28 Texas Administrative Code, Section §134.204(h)(1)(A) states "For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.

   (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier 'WH.' Each additional hour shall be billed using CPT Code 97456 with modifier 'WH.' CARF accredited Programs shall add 'CA' as a second modifier.

   (B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes."

   The Division finds that the requestor did not provide the CARF accredited modifier; therefore, the monetary value of the program will be 80% of the CARF accredited value. Therefore, in accordance with 28 Texas Administrative Code §134.204(h)(1)(B) and (3)(A) and (B), the MAR for a non-accredited program is $51.20 ($64.00 x 80%) per hour/unit and is reimbursed as follows:

   The MAR for CPT code 97545-WH x 1 unit for DOS September 3, 2008 is $102.40. The carrier paid $93.86 under check number 0068757153. The difference between the MAR and the amount paid is $8.54. This amount is recommended for reimbursement.

The MAR for CPT code 97546-WH x 5 hours for DOS September 3, 2008 is $256.00. The carrier paid $0.00. The difference between the MAR and the amount paid is $256.00. This amount is recommended for reimbursement.

The MAR for CPT code 97546-WH x 4 hours for DOS September 5, 2008 is $204.80. The carrier paid $199.10 under check number 0068757154. The difference between the MAR and the amount paid is $5.70. This amount is recommended for reimbursement.

The total MAR is $563.20, the respondent has previously reimbursed the amount of $292.96 for the disputed services. Therefore, the requestor is entitled to additional reimbursement in the amount of $270.24.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ 270.24.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $270.24 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 25, 2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.